Nutrition & Health History

Name: _____ Email: _____

DOB: _____ Age:_____ Height:_____

Weight History

- Current body weight: _____
- (Highest _____in the last 5 years) (Lowest _____in the last 5 years)

Medical

Reason for nutrition counseling: _____

Current diagnosis, if applicable: _____

Current medications: _____

_____

Medical history: _____

Lifestyle

Exercise: Yes / No If yes, how often? _____ Type: _____

Other Physical Activity: _____

Tobacco Yes/No: _____

Diet

Supplements: _____

_____

Food allergies: _____

Food dislikes: _____

Who prepares food in your home? _____ # in household _____

If Applicable, average servings per week:

Alcohol: Beer _____

Wine _____

Hard liquor _____

What is your primary goal for your nutrition counseling experience? _____

_____

How did you hear about JTA Wellness? _____

Afton Oaks Bldg. II - 400 N. Loop 1604 E., Suite 175, San Antonio, TX 78232
(210) 545-4422 ph (210) 545-4495 fax

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION (Please Print)

Name: _____Date of Birth: _____SS#:_____

Address: _____

Phone: _____Email:_____

Primary Insurance Provider: _____(PPO___ HMO___)

ID#:_____ Group#:_____

Subscriber: _____ Date of Birth: _____

Secondary Insurance (if applicable):_____

ID#:_____ Group#:_____

Subscriber: _____ Date of Birth: _____

RELEASE OF MEDICAL RECORDS FROM:

NAME: _____
TEL: _____
FAX: _____

Please release a copy of all my medical records to JTA Wellness, including but not limited to, progress notes, operative notes, laboratory results, diagnostic tests, and a list of currently prescribed medications.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____Date: _____

HIPAA: I have read and have access to the HIPAA (Health Insurance Portability and Accountability Act) policies.

Signature: _____ Date: _____

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PAYMENT POLICIES EFFECTIVE 10/27/15

In light of the declining economy and rising healthcare costs, payment for services is due on the date of service by cash, check or credit card unless the patient provides prior authorization from their insurance carrier. In that event, only patient's required co-pay will be collected.

JTA will file claims and receive payment from the insurance company. Any unpaid balance will be the patient's responsibility. If the insurance company disallows charges for any reason, the balance due will be charged to the patient's credit card on file. **In the event that the patient declines to furnish a credit card, payment in full is expected on the day of the appointment. All unpaid patient balances will be subject to reporting to a collection agency.**

Credit Card Authorization

o Visa o MasterCard o Discover o American Express o Debit

Number_____ Expiration Date_____

Last three numbers from back of card _____

Any questions or concerns regarding JTA Wellness payment policy should be directed to our billing office at (210)545-4422. My signature below signifies that I have read, understand, and agree to abide by the above policies, and grants my permission to JTA Wellness to charge my credit card for any remaining balance not covered by my insurance company.

Patient agrees to provide at least 24-hour notice of cancellation of an appointment and understands that not showing up for an appointment can result in a charge of $25.00 on your account. Failure to pay a no-show fee will be treated the same as our policy on unpaid patient balances and will be subject to report to a collection agency if unpaid.

Signature_____ Date: _____